U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 14 March 2006

Case No.: 2004-BLA-5581

In the Matter of:

BOBBY J. OSBORNE
Claimant

v.

WHITAKER COAL CORPORATION
Employer

SUN COAL COMPANY, INC.
Carrier

and

DIRECTOR,OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Edmond Collett, Esq.
For the claimant

Lois A. Kitts, Esq.
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the "Act"). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

Mr. Bobby J. Osborne, represented by counsel, appeared and testified at the formal hearing held August 30, 2005 in Hazard, Kentucky. I afforded both parties the opportunity to offer testimony, question witnesses and introduce evidence. Thereafter, I closed the record. I based the following Findings of Fact and Conclusions of Law upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. Although the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformity with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, EX and CX refer to the exhibits of the Director, Employer and Claimant, respectively.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Claimant filed his first application for Federal Black Lung benefits on May 8, 1998. (DX 1). After reviewing the relevant evidence, the District Director denied the claim on September 18, 1998. (DX 1). Claimant did not appeal the findings. However, on January 5, 2001, Claimant filed a subsequent claim. (DX 2). The claim was denied by the District Director on April 12, 2001. (DX 2). Claimant did not appeal the denial and the claim was administratively closed due to abandonment. Claimant then filed the instant subsequent claim for benefits on October 3, 2002. (DX 4). The District Director denied the current subsequent claim on October 10, 2003. (DX 26). Claimant then filed a notice contesting the Director's finding and requesting a formal hearing. (DX 27). On January 8, 2004, the claim was transferred to the Office of Administrative Law Judges. (DX 31).

Factual Background

Claimant, Bobby J. Osborne, was born on November 15, 1950. (Tr. 12). Claimant graduated from high school and is married to Bonnie Osborne. (Tr. 13). Claimant worked the majority of his career in coal mine employment and construction. (Tr. 15). During his coal mine employment he worked underground loading coal, shooting coal, as a roof bolter and driving a shuttle car. (Tr. 15-19). Claimant left the mines in 1995. (Tr. 21, DX 4). Claimant testified he suffers from shortness of breath when walking over forty feet. (Tr. 23). Claimant takes Combivent and uses a nebulizer. (Tr. 24).

Claimant testified that he has smoked cigarettes for thirty-eight years. (Tr. 14). Claimant testified at the hearing to currently smoking ten to fifteen cigarettes per day, but that he previously smoked a pack and a half per day for ten years, and then a pack per day for ten to fifteen years. (Tr. 14). At his deposition on March 1, 1996, Claimant stated he had smoked a pack per day since he was eighteen. (DX 21). Dr. Simpao noted in his January 3, 2003 report

that Claimant smoked two packs per day until 2002 and then cut back to five to eight cigarettes per day. (DX 11). Dr. Repsher found that Claimant smoked two packs per day for thirty years and a half a pack per day for seven to eight years. (EX 1). Claimant informed Dr. Rosenberg that he averaged half a pack of cigarettes a day for thirty years. (EX 3). I find based on all the evidence that Claimant smoked two packs of cigarettes per day for thirty years (sixty pack years) and then cut down to ten to fifteen cigarettes per day over the last eight years. Claimant continues to smoke today.

Current Contested Issues

The parties contest the following issues regarding this claim:

1. Whether Claimant's claim was timely filed;

2. Whether Claimant has one dependent for purposes of augmentation;

3. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;

4. Whether Claimant's pneumoconiosis, if present, arose out of coal mine employment;

5. Whether Claimant is totally disabled;

6. Whether Claimant's total disability, if present, is due to pneumoconiosis;

7. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309(c), (d).

8. Whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial per 20 C.F.R. 725.310.[1]

The employer and District Director also contest other issues that are identified at lines 18, 19 and 20(b) on the list of issues. (DX 52). These issues are beyond the authority of an administrative law judge and are preserved for appeal.[2]

Dependency

Claimant alleges one dependent for the purposes of benefit augmentation, namely his wife, Bonnie. (DX 9). They married on June 20, 1969. (DX 9). Claimant submitted the marriage certificate establishing the relationship with his wife and testified as to her dependency.

[1] While this issue has been raised, it does not appear to be applicable herein. Employer designated both modification and subsequent claim analysis as issues; however, Claimant filed this claim more then one year after his prior denial and therefore, this is a subsequent claim. Accordingly, only a subsequent claim analysis will be conducted.

[2] These issues involve the constitutionality of the Act and the regulations. Administrative Law Judges are precluded from ruling on the constitutionality of the Act, and therefore, these issues will not be ruled on herein but are preserved for appeal purposes.

(DX 9, Tr. 13). Accordingly, I find that Claimant has one dependent for the purposes of benefit augmentation.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The Claimant's length of coal mine employment is a non-contested issue. The District Director made a finding of seventeen years. (DX 26). The parties stipulated to this amount at the hearing. Claimant testified to working in coal mine employment between 1969 and 1995. (Tr. 15-23). The documentary evidence includes the Claimant's Social Security earnings report, pay stubs and an employment questionnaire. (DX 5-8). Accordingly, based upon all the evidence in the record, I find that the Claimant was a coal miner, as that term is defined by the Act and Regulations, for seventeen years. He last worked in the Nation's coal mines in 1995. (DX 4; Tr. 23).

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability

due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

Claimant filed two previous claims for benefits on May 8, 1998 and January 5, 2001. The record of the prior claims include only one medical report finding Claimant totally disabled due to pneumoconiosis. The report is discussed below.

Glen Baker, M.D. examined Claimant on April 6, 1995. He issued a report on May 1, 1995 where he opined that Claimant suffered from pneumoconiosis based on a chest x-ray and history of coal dust exposure. (DX 1). He also diagnosed Claimant with chronic obstructive airway disease with mild obstructive defect based on the pulmonary function testing and chronic bronchitis based on Claimant's history. According to Dr. Baker, Claimant is not physically capable from a pulmonary standpoint, to do his usual coal mine employment or comparable work in a dust-free environment. Specifically, Dr. Baker stated Claimant "should have no further exposure to coal dust…due to his coal workers' pneumoconiosis, chronic obstructive airway disease and chronic bronchitis. He would have difficulty doing sustained manual labor, on an 8 hour basis, even in in a dust-free environment, due to these conditions." Dr. Baker states Claimant's impairment is due to pneumoconiosis and smoking. (DX 1).

Dr. Baker's opinion is unreasoned for a number of reasons. First, he provided no basis for his opinion besides the fact that he found Claimant suffers from the pneumoconiosis, chronic obstructive airway disease, resting arterial hypoxemia and chronic bronchitis. An opinion of the inadvisability of returning to coal mine employment because of pneumoconiosis is not the equivalent of a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.,* 12 BLR 1-83 (1988). Next the pulmonary function testing performed by Dr. Baker produced non-qualifying results and he failed to explain the inconsistency between his report and the objective testing. Last, the x-ray film reading upon which Dr. Baker uses to base his opinion of pneumoconiosis is not in the record. Therefore, any opinions based on the film cannot be considered. Therefore, Dr. Baker's finding of total disability due to pneumoconiosis is unreasoned.

In order for a medical report to constitute notice, it must be a well-reasoned opinion that Claimant was totally disabled due to pneumoconiosis. Therefore, I find that Employer has not rebutted the presumption of Section 725.308(c), and that this claim was timely filed. Furthermore, even if I had found the medical report well-reasoned, the communication element is not satisfied. The fact that the medical report of Dr. Baker is in the record, does not mean the communication requirement is satisfied. I am not inclined to assume that simply because a medical report was in the record or in the possession of Claimant's attorney, is proof that the findings were "communicated" to Claimant. In fact, the presumption under §725.308(c) is that every claim is timely. Assuming that access to a report equates to communication by a physician would severely undermine §725.308(c). Furthermore, although Claimant testified at the August 30, 2005 hearing and in his deposition regarding his breathing condition, he never stated that a physician ever informed him that he was totally disabled due to pneumoconiosis. Accordingly, I find that Claimant's testimony also does not support Employer's contention that the instant claim is untimely.

Employer argues in its post hearing brief that the treatment records from Mary Breckinridge Hospital rebut the presumption of timeliness. (DX 13). However, nowhere in the treatment records is there a finding of total disability due to pneumoconiosis. The records relate to treatment Claimant received between 1998 and 2002. The records reveal that Claimant was diagnosed with chronic obstructive pulmonary disease; however, the records never link the disease to coal mine employment. There is one note that states Claimant worked in the mines for twenty-three years but that is the only time coal mine employment is ever mentioned in the records. Claimant's ability to perform his regular coal mine employment or other related employment is never discussed. Therefore, the treatment records do not support Employer's contention that the instant claim is untimely. (DX 13).

Accordingly, concerning timeliness, I have found that the medical report of Dr. Baker is not a well-reasoned opinion diagnosing total disability due to pneumoconiosis. In addition, the treatment records from Mary Breckinridge Hospital do not provide a reasoned medical opinion regarding total disability due to pneumoconiosis. The findings of unreasonableness and lack of communication are independently sufficient to defeat Employer's timeliness contention, thus, this claim was timely filed.

Threshold Issue for Subsequent Claims

Under the amended regulations of the Act, the progressive and irreversible nature of pneumoconiosis is acknowledged. 20 C.F.R. § 718.201(c). Consequently, claimants are permitted to offer recent evidence of pneumoconiosis after receiving a denial of benefits. *Id.* The new regulations provide that where a claimant files a subsequent claim more than one year after a prior claim has been finally denied, the subsequent claim must be denied on the grounds of the prior denial unless "Claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. § 725.309(d). If a claimant establishes the existence of an element previously adjudicated against him, only then must the administrative law judge consider whether all the evidence of record, including evidence submitted with the prior claim, supports a finding of entitlement to benefits. *Id.* A duplicate claim will be denied unless Claimant shows that one of the applicable conditions has changed since the date of the previous denial order. *Id; see, also Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994).

Accordingly, because Claimant's previous claim was denied, he now bears the burden of proof to show that one of the applicable conditions of entitlement has changed. 20 C.F.R. § 725.309(d). I must review the evidence developed and submitted subsequent to April 12, 2001, the date of the prior denial, to determine if he meets this burden. *Id.*

The following elements were deemed not shown by Claimant as a result of the initial denial: that he had pneumoconiosis as defined by the Act and the regulations; his pneumoconiosis arose out of coal mine employment; and he is totally disabled due to pneumoconiosis. 20 C.F.R. § 410.410(b).

Newly Submitted Medical Evidence

Medical evidence submitted with a claim for benefits under the Act is subject to the requirement that it must be in "substantial compliance" with the applicable regulations' criteria for the development of medical evidence. *See* 20 C.F.R. §§ 718.101 to 718.107. The regulations address the criteria for chest x-rays, pulmonary function tests, physician reports, arterial blood gas studies, autopsies, biopsies and "other medical evidence." *Id.* "Substantial compliance" with the applicable regulations entitles medical evidence to probative weight as valid evidence.

Secondly, medical evidence must comply with the limitations placed upon the development of medical evidence. 20 C.F.R. § 725.414. The regulations provide that a party is limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy and two medical reports as affirmative proof of their entitlement to benefits under the Act. §§ 725.414(a)(2)(i), 725.414(a)(3)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in one single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test or arterial blood gas study. §§ 725.414(a)(2)(ii), 725.414(a)(3)(ii). Likewise, the District Director is subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i-iii). Furthermore, since this is a subsequent claim only evidence submitted after April 12, 2001 will be considered unless a material change in physical condition is proven. 20 C.F.R. § 725.309(d).

A. X-ray Reports[3]

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 11	1/6/03	Simpao	½
DX 14	1/6/03	Scott BCR/B-reader	Completely negative
EX 3	6/18/03	Rosenberg B-reader	Completely negative
EX 1	5/19/04	Repsher B-reader	No abnormalities consistent with pneumoconiosis

[3] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a) and (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

B. Pulmonary Function Studies[4]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 11 1/6/03	Simpao	52/ 71"	0.56	1.30	30	43	Yes	Good Cooperation and understanding
EX 3 6/18/03	Rosenberg	52/ 71"	1.00	2.12	37	47	Yes	Pre-bronchodilator Good cooperation, effort and understanding
EX 3 6/18/03	Rosenberg	52/ 71"	1.57	3.09	53	51	Yes	Post-bronchodilator Good Cooperation, effort and understanding
EX 1 5/19/04	Repsher	53/ 70"	0.81	2.27	32	35	Yes	Pre-bronchodilator Understood, cooperated well and good effort
EX 1 5/19/04	Repsher	53/ 70"	1.35	3.45	57	39	Yes	Post-bronchodilator Understood, cooperated well and good effort

C. Blood Gas Studies[5]

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 11	1/6/03	Simpao	41.2	54.5	R	None
EX 3	6/18/03	Rosenberg	36.8	64.0	R[6]	
EX 1	5/19/04	Repsher	38.0	69.1	R[7]	

[4] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c). The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Benefits Review Board (the "Board") has held that a ventilatory study which is accompanied by only two tracings is in substantial compliance with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). The values from the FEV_1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

[5] Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).

[6] Although the results of the arterial blood gas studies are discussed in Dr. Rosenberg's report, the actual study is not in the record. As these studies are not contained in the record, an administrative law judge cannot review them for accuracy. The Benefits Review Board ("Board") has held that a report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984).

D. Narrative Medical Evidence

Valentino Simpao, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, examined Claimant on January 6, 2003, at which time he took a patient history of symptoms and recorded an employment history of twenty-one years as an underground miner. (DX 11). Dr. Simpao noted Claimant had a history of frequent colds, pneumonia, wheezing attacks, chronic bronchitis, arthritis and high blood pressure. He recorded a smoking history of two packs per day between 1973 and 2002, and that Claimant then cut down to five to eight cigarettes a day. Claimant's symptoms included sputum production (1/2 cup brown sputum daily for ten years), wheezing with rest and exertion (ten years), dyspnea (daily upon exertion and rest, ten years), productive cough (ten years), chest pain (when coughing, ten years), orthopnea (ten years), paroxysmal nocturnal dyspnea (seven to eight years) and shortness of breath when walking over one-fourth of a mile or climbing two fights of stairs. In addition, Dr. Simpao performed pulmonary function tests, arterial blood gas studies, a chest x-ray, EKG and physical examination on Claimant. Upon palpation, Dr. Simpao found tactile fremitus, increased right over left. At percussion he found increased resonance in the upper chest and axillary areas. (DX 11).

After reviewing the results of the examination and tests, Dr. Simpao diagnosed Claimant with coal workers' pneumoconiosis 1/2. (DX 11). Dr. Simpao based his opinion on Claimant's coal dust exposure and chest x-ray. He found Claimant suffered from a severe degree of both restrictive and obstructive airway disease based on the pulmonary function testing and ventilatory perfusion with hypoxia based on the arterial blood gas studies. In Dr. Simpao's opinion, Claimant has a severe impairment rating due to pneumoconiosis. (DX 11).

Dr. Simpao submitted a supplemental medical report on July 13, 2005. (DX 34)[8]. Dr. Simpao maintains that Claimant's history of coal dust exposure is a significant contributing factor of his pneumoconiosis. Dr. Simpao acknowledges that Claimant's smoking history is also an aggravating factor in his pulmonary disease. He opines that Claimant does not have the respiratory capacity to perform his regular coal mine employment and that Claimant is totally disabled from his pulmonary disease. (DX 34).

David M. Rosenberg, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, examined Claimant on June 18, 2003 and issued a medical report on Claimant's condition on June 30, 2005. (EX 3). Dr. Rosenberg reviewed Claimant's symptoms and recorded an employment history in the underground coal mines for twenty-three years. He found that Claimant starting smoking at age 18 and averaged half a pack of cigarettes per day over the years. Dr. Rosenberg noted Claimant had a history of hospitalization for chronic obstructive pulmonary disease. At the time of the evaluation, Claimant complained of shortness of breath when walking short distances, wheezing, cough, sputum production and back pain. Upon

[7] Dr. Repsher's arterial blood gas report does not specify the altitude at which the test was connected and therefore, I will not consider it when making my findings for it does not meet the regulation requirements. 20 C.F.R. § 718.105(c)(2).

[8] At the hearing Employer objected to the admittance of Dr. Simpao's supplemental report into evidence (DX 34). However, I find good cause to admit the evidence into the record.

physical examination, Dr. Rosenberg noted Claimant became short of breath with minimal activity. Upon auscultation, the chest examination revealed diminished breath sounds with hyperresonance, without rales, rhonchi or wheezing. Claimant had no murmurs, gallops or rubs. Dr. Rosenberg performed a chest x-ray, EKG, pulmonary function tests and arterial blood gas studies on Claimant. He also reviewed all the other medical evidence in the record. (EX 3).

Dr. Rosenberg stated that Claimant's EKG "revealed a normal sinus rhythm with an intraventricular conduction delay and left axis deviation and a widened ORS complex." (EX 3). Dr. Rosenberg noted that Claimant's chest x-ray revealed no evidence of micronodularity associated with coal dust exposure. He opined Claimant does not have pneumoconiosis. Dr. Rosenberg based his opinion on Claimant's physical examination, chest x-ray, normal diffusing capacity measurement and normal total lung capacity. Dr. Rosenberg acknowledged that Claimant's pulmonary function testing showed a severe degree of disabling obstructive lung disease. He found that Claimant has a reduced PO_2 level and an elevated carboxyhemoglobin level. Dr. Rosenberg opined that from a functional perspective Claimant cannot perform his regular coal mine employment. He diagnoses Claimant with chronic obstructive pulmonary disease. However, he does not attribute Claimant's impairment to coal dust exposure. Dr. Rosenberg states that the decrease in FEV_1 percentage in combination with Claimant's marked air trapping is not the result of coal dust exposure. He opines that Claimant's bronchodilator response illustrates that coal dust is not the cause of Claimant's impairment. Dr. Rosenberg opines that Claimant's symptoms and impairment are directly related to his long history of smoking and not coal dust exposure. (EX 3).

Dr. Rosenberg provided a supplemental report on August 26, 2005. (EX 5). Dr. Rosenberg reviewed Dr. Simpao's supplemental report and the other evidence in the record. He noted that, despite Dr. Simpao's report, his opinion remains the same. Dr. Rosenberg agreed with Dr. Simpao that Claimant has a respiratory impairment but disagreed on the cause. He based his opinion "on the data describing impairment in coal miners reported by Attfield and Houdus, Morgan and Soutar and Hurley, and supported by NIOSH's recommended Standards regarding Respirable Coal Mine Dust." Dr. Rosenberg reiterates his opinion that Claimant's impairment is typical of chronic obstructive pulmonary disease related to smoking. (EX 5).

In addition, the record includes a deposition of Dr. Rosenberg taken on August 9, 2005. (EX 4). Dr. Rosenberg reiterated the findings in his report and further testified that he opined Claimant does not suffer from pneumoconiosis or a chronic obstructive lung disease related to coal dust exposure. Dr. Rosenberg attributes Claimant's chronic obstructive pulmonary disease to his long history of cigarette smoking. Dr. Rosenberg agreed that Claimant does not have the capacity to return to his ordinary coal mine employment but opined his impairment is solely related to smoking. (EX 4).

Lawrence Repsher, M.D., Board-certified in Internal Medicine and Pulmonary Diseases, examined Claimant on May 19, 2004, at which time he reviewed the Claimant's symptoms and recorded an occupational history of twenty-three years in underground coal mine employment. (EX 1). He noted Claimant worked as a tram operator, hauling coal. During the examination, Claimant reported progressive dyspnea upon exertion, chronic productive cough, sputum production, chest pain upon exertion, history of abnormal EKGs, orthopnea, possible ankle

edema, paroxysmal nocturnal dyspnea and hypertension. Dr. Repsher stated Claimant's smoking history revealed two packs of cigarettes per day for thirty years and half a pack per day for the last seven to eight years. Upon physical examination, Dr. Repsher found Claimant's breath sounds were normal, the expiratory phase was not prolonged and there were no rales, rhonchi or wheezes. Dr. Repsher performed a chest x-ray, pulmonary function tests, and arterial blood gas studies on Claimant. (EX 1).

Dr. Repsher found no evidence of pneumoconiosis on Claimant's chest x-ray. However ,he opined that the pulmonary function testing revealed a severe obstructive ventilatory impairment with excellent bronchodilator responsiveness. (EX 1). Dr. Repsher noted Claimant's lung volumes showed hyperinflation, air trapping and that his diffusion capacity was mildly reduced. He opined that the "pulmonary function tests are consistent with chronic bronchitis and an element of pulmonary emphysema, related to [Claimant's] long, continuing, and substantial cigarette smoking history." (EX 1). Claimant's carboxyhemoglobin levels were significantly high. Overall, Dr. Repsher found no evidence of pneumoconiosis but diagnosed Claimant with coronary heart disease, hypertension, possible early chemical diabetes mellitus and chronic obstructive pulmonary disease caused by smoking. Based on the negative chest x-ray, pulmonary function testing and bronchodilator responsiveness, Dr. Repsher found Claimant's condition was in no way related to coal mine employment. (EX 1).

In addition, the record includes a deposition of Dr. Repsher taken on July 8, 2004. (EX 2). Dr. Repsher reiterated the findings in his report and further testified that he opined Claimant does not suffer from pneumoconiosis and that Claimant's pulmonary impairment is directly related to his long history of smoking. Based on the objective testing and physical examination, Dr. Repsher opined that Claimant's condition is not related to coal dust exposure. (EX 2).

F. Hospital and Treatment Records

The amended regulations provide that, notwithstanding the evidentiary limitations contained at 20 C.F.R. § 725.414(a)(2) and (a)(3), "any record of a miner's hospitalization for respiratory or pulmonary or related disease may be received into evidence." 20 C.F.R. § 725.414(a)(4). Furthermore, a party may submit other medical evidence reported by a physician and not specifically addressed under the regulations under Section 718.107, such as a CT scan. The record contains hospital and treatment records from Mary Breckinridge Hospital between October 1998 and September 2002.

Claimant was examined on October 9, 1998 by Ray Varghese, M.D., who noted Claimant's symptoms included cough, sputum production, fever and chills. Dr. Varghese stated that Claimant worked in coal mine employment for twenty-three years and used to smoke. Upon examination, Claimant's chest revealed bilateral rhonchi and a few basilar rales were present on both sides. There was no bronchial breathing. Dr. Varghese ordered a chest x-ray. Ashok Patel, M.D. read the chest x-ray film and noted Claimant's soft tissue, bony cage and diaphragms were unremarkable. He noted a patchy infiltration in the right lower lobe. The remaining lungs were clear. Claimant was diagnosed with chronic obstructive pulmonary disease.

On June 17, 1999, Claimant was hospitalized for chronic obstructive pulmonary disease and bronchitis. Claimant's symptoms included shortness of breath, yellow sputum, cough, fever and chills. The records noted a history of chronic obstructive pulmonary disease and a pack per day smoking habit. Upon examination, Claimant's lung sounds included bilateral rhonchi with wheezing and diminished breath sounds. Claimant was treated with a nebulizer every six hours.

Claimant was diagnosed with pneumonia on July 13, 1999. A chest x-ray was ordered revealing PA and lateral views of the chest showing no pulmonary infiltrate or other active lung disease processes within the cardiomediastinal silhouette. The chest study was normal.

Dr. Varghese examined Claimant again in 2001. He diagnosed Claimant with chronic obstructive pulmonary disease and chronic bronchitis. Dr. Varghese stated that these conditions were moderately severe. He acknowledged that Claimant was still smoking one pack per day.

On April 26, 2002, Dr. Varghese advised Claimant to quit smoking and discussed the problems that could occur if he continued to smoke. Claimant was again diagnosed with chronic obstructive pulmonary disease and Combivent was prescribed. Claimant informed Dr. Varghese that the Combivent was not working and that he quit smoking for three days but started back. Upon examination, Claimant's lungs were clear with no bilateral breath sounds, wheezes, crackles or rubs.

In August and September 2002, Dr. Varghese treated Claimant for chronic obstructive pulmonary disease. He continued to advise Claimant to quit smoking. Claimant was also diagnosed with pneumonia.

Throughout the treatment records, Claimant is consistently diagnosed with chronic obstructive pulmonary disease. However the records never attribute the disease to coal mine employment. Dr. Varghese mentions once in the records that Claimant worked in the coal mines but he never connects coal dust exposure to Claimant's respiratory and pulmonary impairments.

Previously Submitted Medical Evidence (Claimant's First Claim)

A. X-ray Reports

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 1	5/22/98	Wicker B-reader	No abnormalities
DX 1	5/22/98	Sargent BCR/B-reader	No abnormalities
DX 1	2/26/96	Westerfield B/reader	Negative
DX 1	6/19/95	Myers B-reader	1/1
DX 1	3/23/95	Anderson N/A	1/1
DX 1	3/23/95	Lane N/A	1/1

B. Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments

DX 1 3/12/98	Baker	47/ 70¼"	1.89	4.00	N/A	47.25	Yes	No comments
DX 1 7/13/98	Wicker	47/ 71"	1.52	3.70	55.58	41	Yes	Fair-Dr. Wicker stated that he felt the test was invalid
DX 1 7/13/98	Wicker	47/ 71"	1.39	3.49	51.43	39.8	Yes	Poor effort- not valid
DX 1 4/20/95	Baker	44/ 70"	2.48	4.82	N/A	51.45	Yes	No comments
DX 1 6/19/95	Myers	44/ 70.5"	2.33	3.65	N/A	63.8	Yes	Pre-bronchodilator Maximum effort and cooperation
DX 1 6/19/95	Myers	44/ 70.5"	2.45	4.07	N/A	60.19	Yes	Post- bronchodilator Maximum effort and cooperation

C. Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 1	5/22/98	Wicker	36.7	81.8	R	None
DX 1	5/22/98	Wicker	42	84.5	E	None

D. Narrative Medical Evidence

Glen Baker, M.D., examined Claimant on April 20, 1995 and issued a report on May 1, 1995, based on his findings. (DX 1). Dr. Baker performed an employment history finding Claimant worked twenty-three years in underground coal mine employment. He found Claimant smoked for twenty-five years at a rate of one pack per day and continues to smoke. Dr. Baker stated Claimant has a history of difficulty breathing (ten years), cough (daily), sputum production, wheezing, trouble sleeping due to his breathing condition and pneumonia. Upon physical examination, Claimant's lungs were clear with no rales or wheezes detected. Dr. Baker performed a chest x-ray and pulmonary function tests on Claimant. (DX 1).

Dr. Baker diagnosed Claimant with pneumoconiosis based on his chest x-ray and history of coal dust exposure;[9] chronic obstructive airway disease with borderline mild to moderate obstructive pulmonary defect based on the pulmonary function testing; and, chronic bronchitis based on Claimant's history. (DX 1). Dr. Baker opined that Claimant has a pulmonary impairment as a result of his coal dust exposure, pneumoconiosis and smoking history. He stated that Claimant cannot perform his usual coal mine employment. Dr. Baker stated that Claimant should have no further exposure to coal dust due to his pneumoconiosis, chronic obstructive airway disease and chronic bronchitis. (DX 1).

[9] Dr. Baker's actual reading of the April 6, 1995 x-ray film was never submitted into the record. Therefore, I cannot take into consideration the x-ray or any opinions based on the film.

John E. Myers, Jr. M.D. examined Claimant on June 19, 1995. (DX 1). Dr. Myers noted that Claimant had an employment history of twenty-three years in underground coal mine employment. He revealed Claimant had a history of arthritis, trouble breathing, pneumoconiosis, dyspnea, coughing, swelling ankles, anterior chest pain, pneumonia and high blood pressure. Dr. Myers stated that Claimant smoked two packs of cigarettes per day for twenty-five years but cut down to one pack per day. Upon physical examination, Dr. Myers noted Claimant was well-developed and appeared in no acute distress. Claimant's chest expansion was one and a quarter inches at the xiphoid process and his breath sounds revealed rhonchi, wheezes and significant impairment of air exchange. Dr. Myers also performed pulmonary function tests, an electrocardiogram and chest x-ray on Claimant. (DX 1).

Dr. Myers diagnosed Claimant with pneumoconiosis, hypertensive vascular disease, chronic obstructive pulmonary disease and observed Claimant for arteriosclerotic heart disease with angina, but it was not verified. (DX 1). He found Claimant's chest x-ray revealed silicosis, category 1/1 pneumoconiosis, and some minimal pleural thickening of the right major fissure from past pneumoconiosis. Dr. Myers noted Claimant's electrocardiogram came back abnormal and illustrated incomplete bundle branch block pattern. He also found a Z wave in the AVL and V1 which could represent an old anterior septal injury. Dr. Myers stated that Claimant's pulmonary function tests revealed a moderate obstructive defect in Claimant's ventilation. Dr. Myers further opined that Claimant has a pulmonary impairment due to pneumoconiosis and obstructive pulmonary disease. However, Dr. Myers found that despite Claimant's pulmonary impairment, he could still perform his usual coal mine employment.

Mitchell Wicker, Jr., M.D. conducted a medical examination of Claimant on May 22, 1998. (DX 1). He conducted an employment and smoking history of Claimant finding Claimant worked in coal mine employment between 1974 and 1995. Dr. Wicker found Claimant smoked one pack of cigarettes per day for thirty-one years. He noted Claimant had a history of pneumonia and wheezing attacks. Claimant's symptoms included sputum production and cough. Dr. Wicker performed a chest x-ray, pulmonary function tests, arterial blood gas studies and physical examination on Claimant. Upon physical examination, Dr. Wicker noted Claimant's lungs were normal to inspection and palpation, but upon auscultation he noted rhonchi. Dr. Wicker opined Claimant's chest x-ray revealed no pneumoconiosis. However, he was unable to determine Claimant's respiratory capacity due to Claimant's failure to comply with testing protocol. (DX 1).

Previously Submitted Medical Evidence (Claimant's Second Claim)

A. X-ray Reports

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
DX 2	1/18/01	Wicker B-reader	Negative for Pneumoconiosis
DX 2	1/18/01	Sargent BCR/B-reader	Negative for Pneumoconiosis

B. Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 2 1/18/01	Wicker	50/ 71"	1.35	2.82	48	48	Yes	Good Effort Pre-bronchodilator
DX 2 1/18/01	Wicker	50/ 71"	1.79	3.35	51	53	Yes	Good Effort Post-bronchodilator
DX 2 2/23/01	Wicker	50/ 71"	1.53	3.17	63	48	Yes	Good[10]

C. Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 2	1/18/01	Wicker	41.3	82	R	
DX 2	1/18/01	Wicker	41.8	88	E	

D. Narrative Medical Evidence

Mitchell Wicker, Jr., M.D. performed a medical examination of Claimant on January 18, 2001. (DX 2). Dr. Wicker performed an employment and smoking history on Claimant. He found Claimant worked twenty-three years in coal mine employment and smoked one pack of cigarettes per day since he was eighteen years old. Dr. Wicker noted Claimant had a history of pneumonia, chronic bronchitis and arthritis. Claimant's symptoms included sputum production, wheezing, dyspnea, cough, chest pain, orthopnea, ankle edema and paroxysmal nocturnal dyspnea. Dr. Wicker performed a chest x-ray, pulmonary function studies, arterial blood gas studies and physical examination on Claimant. Upon physical examination, the physician noted Claimant's lungs were clear to auscultation and normal to inspection and palpation. Dr. Wicker opined Claimant's chest x-ray revealed no signs of pneumoconiosis. However, he found Claimant was severely disabled and unable to return to his past coal mine employment due to his past history of cigarette smoking. He based his opinion on Claimant's objective medical testing.

DISCUSSION AND APPLICABLE LAW

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, Claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. § 725.202(d)(2)(i-iv). Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989).

[10] Dr. Burki invalidated the pulmonary function studies conducted by Dr. Wicker on January 18, 2001 and February 23, 2001 due to inadequate effort and lack of flow volume loops enclosed. (DX 2).

Pneumoconiosis and Causation

Section 718.202 provides four means by which pneumoconiosis may be established: chest x-ray, biopsy or autopsy, presumption under §§ 718.304, 718.305 or 718.306, or if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a). The regulatory provisions at 20 C.F.R. § 718.201 contain a definition of "pneumoconiosis" provided as follows:

> (a) For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal," pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

§ 718.201(a).

It is within the administrative law judge's discretion to determine whether a physician's conclusions regarding pneumoconiosis are adequately supported by documentation. *Lucostic v. United States Steel Corp*., 8 B.L.R. 1-46, 1-47 (1985). "An administrative law judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *See King v. Consolidation Coal Co*., 8 B.L.R. 1-262, 1-265 (1985).

A. X-ray Evidence

Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater

weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The chest x-rays in the record do not support a finding of pneumoconiosis. Dr. Simpao found the January 6, 2003 x-ray film positive for pneumoconiosis; however, the x-ray was re-read as negative by Dr. Scott, a Board-certified radiologist and B-reader. As such, I find this x-ray negative. Dr. Rosenberg, a B-reader, found the June 18, 2003 x-ray film negative and Dr. Repsher, a B-reader, found the May 19, 2004 x-ray film negative. Accordingly, I find the preponderance of negative x-ray readings outweigh the positive readings. Therefore, pneumoconiosis has not been established under § 781.202(a)(1).

B. Autopsy/Biopsy

Pursuant to Section 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

C. Presumptions

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

D. Medical Opinions

Section 718.202(a)(4) provides another way for a claimant to prove that he has pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion might support the presence of the disease if it is supported by adequate rationale, notwithstanding a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22, 1-24 (1986). The weight given to a medical opinion will be in proportion to its well-documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and

patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director*, OWCP, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp*., 2 B.L.R. 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*).

Dr. Simpao's report concluded Claimant suffers from pneumoconiosis. (DX 11). He bases his opinion on Claimant's coal dust exposure and chest x-ray. In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone does not tend to establish that he has any respiratory disease arising out of coal mine employment. *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id*.

Acknowledging that Dr. Simpao performed other physical and objective testing, he listed that he expressly relied on Claimant's positive x-ray and coal dust exposure for his clinical determination of pneumoconiosis. Moreover, he failed to state how the results from his other objective testing might have impacted his diagnosis of pneumoconiosis. In addition, Dr. Simpao diagnosed Claimant with a severe degree of both restrictive and obstructive airway disease based on the pulmonary function testing. However, Dr. Simpao fails to opine Claimant's obstructive airway disease is chronic. Therefore, his diagnosis does not constitute a finding of legal pneumoconiosis. (DX 11). Dr. Simpao fails to explain how his other physical findings and Claimant's symptomatology provide a basis for a diagnosis of pneumoconiosis. Also Dr. Simpao's findings are not supported by the evidence in the record. Therefore, I find Dr. Simpao's report unreasoned and I give it little weight.[11]

[11] The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." § 725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(*en banc*); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

In this Decision and Order, I have found that Claimant's complete pulmonary evaluation by Dr. Simpao is unreasoned for purposes of determining pneumoconiosis as noted above. However, even if Dr. Simpao's opinion was well reasoned, Claimant could not prevail due to the preponderance of the evidence finding no pneumoconiosis. Therefore, I find that remand of this case would be futile. *Larioni v. Director, OWCP*, 6 B.L.R. 1-1276 (1984); *see, e.g.*, *Mullins v. Director, OWCP*, No. 05-0295 BLA (BRB, Jul. 27, 2005)(unpub.); *Bowling v. Director, OWCP,* No. 05-0327 BLA (BRB, Jul. 29, 2005)(unpub.).

In contrast, Dr. Rosenberg's report concluded Claimant does not have pneumoconiosis. (EX 3). To support his opinion, Dr. Rosenberg notes upon physical examination, Claimant's total lung capacity was normal and his chest x-ray did not reveal micronodularity. Dr. Rosenberg's opinions are consistent with the probative chest x-ray evidence of record. Dr. Rosenberg found based on the objective medical testing and physical examination that Claimant's pulmonary problems are directly related to cigarette smoking and not coal dust exposure. He further explained his findings in his supplemental report issued August 26, 2005 and his deposition taken August 9, 2005. (EX 4-5). Dr. Rosenberg also reviewed the other medical evidence and reports in the record. He based his opinions on a more complete consideration of Claimant's current status regarding his smoking history and results on pulmonary testing and chest x-rays. I find Dr. Rosenberg's medical report is well-reasoned and well-documented regarding pneumoconiosis.

Dr. Repsher also opined Claimant does not have pneumoconiosis. (EX 1). Dr. Repsher bases his opinion on his own findings upon physical examination and review of the medical evidence. His opinions are consistent with the probative chest x-ray evidence of record. Dr. Repsher based his opinions on a more complete consideration of Claimant's current status regarding his smoking history and results on pulmonary testing and chest x-rays. Dr. Repsher opined that Claimant's problems are directly related to smoking and not coal dust exposure. He diagnosed Claimant with chronic obstructive pulmonary disease but he did not attribute it to coal dust exposure. Dr. Repsher further explains his findings and reasoning in his July 8, 2004 deposition. (EX 2). I find Dr. Repsher's medical report is well-reasoned and well-documented regarding pneumoconiosis.

I have considered all the evidence under Section 718.202(a); and I find the probative negative x-ray reports and the more complete, comprehensive and better supported medical opinion reports of Drs. Rosenberg and Repsher outweigh the unreasoned report of Dr. Simpao and the other contrary evidence of record. Thus, I find Claimant has failed to demonstrate, by a preponderance of the evidence, the existence of pneumoconiosis.

Causation of Pneumoconiosis

Once it is determined that a claimant suffers from pneumoconiosis, it must be determined whether Claimant's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). The burden is upon Claimant to demonstrate by a preponderance of the evidence that his/her pneumoconiosis arose out of his coal mine employment. 20 C.F.R. § 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arouse out of such employment.

Id.

Since I have found that Claimant failed to prove that he has pneumoconiosis, the issue of whether pneumoconiosis arose out of his employment in the coal mines is moot.

Total Disability

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991). A claimant can be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if in absence of contrary probative evidence, the evidence meets one of the Section 718.204(b)(2) standards for total disability. The regulation at Section 718.204(b)(2) provides the following criteria to be applied in determining total disability: 1) pulmonary function studies; 2) arterial blood gas tests; 3) a cor pulmonale diagnosis; and/or, 4) a well-reasoned and well-documented medical opinion concluding total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1987).

A. Pulmonary Function Tests

Under Section 718.204(b)(2)(i) total disability may be established with qualifying pulmonary function tests.[12] To be qualifying, the FEV_1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1- 154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, I may accord greater weight to the opinion of a physician who reviewed the tracings. *Street v. Consolidation Coal Co.*, 7 B.L.R. 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. *Inman v. Peabody Coal Co.*, 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited a poor cooperation or comprehension. *See, e.g., Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984). However, a non-conforming study may be entitled to probative weight where the results are non-qualifying. The Board has stated that a report's lack of cooperation and comprehension statements does not

[12]A qualifying pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A non-qualifying test produces results that exceed the table values.

lessen the reliability of the study when it is non-qualifying. *Crapp v. U.S. Steel Corp.*, 6 B.L.R. 1-476 (1983).

In the pulmonary function tests of record, there is a small discrepancy in the height attributed to Claimant. The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). In analyzing the pulmonary function test results, I shall utilize the average height reported for Claimant, seventy-one inches.

The pulmonary function tests of record all conform to the applicable quality standards. All the pulmonary function tests produced qualifying values. Accordingly, I find per Section 178.204(b)(2)(i), Claimant has established total disability.

B. Blood Gas Studies

Under Section 718.204(b)(2)(ii) total disability may be established with qualifying arterial blood gas studies. All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1980). This includes testing conducted before and after exercise. *Coen v. Director, OWCP*, 7 B.L.R. 1-30 (1984). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner or circumstances surrounding the testing affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 B.L.R. 1-788 (1984) (miner was intoxicated).

The January 6, 2003 arterial blood gas study is the only study of record complying with regulation requirements and it produced qualifying results. Accordingly, I find per Section 178.204(b)(2)(ii), Claimant has established total disability.

C. Cor Pulmonale

There is no medical evidence of cor pulmonale in the record, therefore, I find Claimant has failed to establish total disability under the provisions of Section 718.204(b)(2)(iii).

D. Medical Opinions

The final way to establish a totally disabling respiratory or pulmonary impairment under Section 718.204(b)(2) is with a reasoned medical opinion. The opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. *Id*. A claimant must demonstrate that his respiratory or pulmonary condition prevents him from engaging in his "usual" coal mine employment or comparable and gainful employment.
20 C.F.R. § 718.204(b)(2)(iv).

The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions. In assessing total disability under Section 718.204(b)(2)(iv), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of

Claimant's usual coal mine employment with a physician's assessment of Claimant's respiratory impairment. *Budash v. Bethlehem Mines Corp.*, 9 B.L.R. 1-48, 1-51 (holding medical report need only describe either severity of impairment or physical effects imposed by claimant's respiratory impairment sufficiently for administrative law judge to infer that claimant is totally disabled). Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform comparable and gainful work pursuant to Section 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

The physicians' reports are set forth above. In summary, Dr. Simpao performed an employment history upon Claimant finding he worked as a carrier operator in the underground mines for twenty-one years. (DX 11). Dr. Simpao opined Claimant has a severe pulmonary impairment which prevents him from having the respiratory capacity to perform the work of a coal miner. (DX 11, 34). He found that Claimant is totally disabled. Dr. Simpao based his opinion on Claimant's pulmonary function tests and arterial blood gas studies. The objective testing performed by Dr. Simpao produced qualifying results, and therefore, the objective testing supports Dr. Simpao's opinion. I find Dr. Simpao's diagnosis regarding total disability is well-reasoned and well-documented.

A medical opinion does not have to be wholly reliable or wholly unreliable; rather, the opinion can be divided into the relevant issues of entitlement to determine whether it is reasoned and documented with regard to any particular issue. *See Drummond Coal Co. v. Freeman*, 17 F.3d 361 (11th Cir. 1994); *Billings v. Harlan #4 Coal Co.*, B.R.B. No. 94-3721 B.L.A. (June 19, 1997) (*en banc) (*unpub.). Accordingly, I divide Dr. Simpao's opinions into the relevant issues of pneumoconiosis and total disability. (DX 10). As noted above with respect to pneumoconiosis, Dr. Simpao's report is not well-reasoned or well-documented. However, in examining the second issue of total disability, Dr. Simpao's opinion is supported by objective medical data and testing. Moreover, it is consistent with the other evidence of record.

Dr. Rosenberg acknowledges that Claimant has a pulmonary impairment and that from a functional perspective Claimant is unable to perform his regular coal mine employment. However, he opines that Claimant's impairment it is not caused by coal dust exposure. (EX 3-4, 5). Dr. Rosenberg bases his opinion on his own examination and the other medical evidence in the record. He states Claimant's total lung capacity is normal as indicated by the pulmonary function test. Dr. Rosenberg also took into consideration the other medical reports and objective testing of record. His opinion is consistent with the probative pulmonary function studies of record. Dr. Rosenberg further explained his findings and opinions in his August 26, 2005 supplemental report and deposition dated August 9, 2005. (EX 4, 5). I find Dr. Rosenberg's medical report is well-reasoned and well-documented regarding total disability.

Dr. Repsher also opines Claimant suffers from a severe pulmonary impairment. (EX 1). Dr. Repsher diagnosed Claimant with chronic obstructive pulmonary disease caused by his long history of smoking. His opinion is consistent with the probative pulmonary function studies of record. However, in Dr. Repsher's report he never makes a determination on whether Claimant could return to his regular coal mine employment. In his deposition he states that he believes

"Claimant is quite disabled—and indeed he meets the social security criteria for pulmonary disability." (EX 2, p. 35). This is the extent of Dr. Repsher's disability analysis except for his discussion on the causes of Claimant's pulmonary condition. Since Dr. Repsher fails to make an adequate finding of total disability, I give his opinion little weight regarding total disability.

The record contains two well-reasoned and well-documented opinions regarding total disability. Both physicians are Board-certified in Internal Medicine and Pulmonary Diseases. Therefore, I find Claimant has established total disability by the probative medical opinion reports of record under the provisions of Section 718.204(b)(2)(iv).

E. Overall Total Disability Finding

Upon consideration of all of the evidence of record, the Claimant has established, by a preponderance of the evidence, total disability. Accordingly, I find the Claimant has established total disability under the provisions of Section 718.204(b) based on the persuasive reports of Drs. Simpao and Rosenberg and the qualifying pulmonary function tests and arterial blood gas study results.

Total Disability Due to Pneumoconiosis

Although the Claimant established total disability, he is nonetheless ineligible for benefits because he failed to show total disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. *See* § 718.204(c)(2). In interpreting this requirement, the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). There are no well-reasoned and well-documented reports of record regarding total disability due to pneumoconiosis. While Dr. Simpao's report is well-documented and well-reasoned as to total disability, it is not as to pneumoconiosis. Therefore, I find that the Claimant has failed to establish total disability due to pneumoconiosis.

Material Change in Condition

As Claimant has established total disability, he has demonstrated, as a matter of law, a material change in condition. As a result, I must consider whether all the record evidence, including the previously submitted evidence, supports a finding of entitlement of benefits.

The record includes two previous claims. I have thoroughly evaluated the previously submitted evidence and taken it into consideration. The previously submitted evidence is summarized above. However, in evaluating the entire record, a medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). *See also Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier). As the medical evidence from the May 8, 1998 claim, dating from 1995 to 1998, is between six and ten years old, I afford these opinions less weight. Pneumoconiosis is a progressive disease. Accordingly, I grant greater weight to the newly submitted evidence as it is the most recent

reflection of the miner's condition. Also the medical evidence from the January 5, 2001 claim supports a finding of no pneumoconiosis. The evidence includes no positive x-ray readings or medical reports finding pneumoconiosis. The 2001 evidence supports my finding that Claimant suffers from total disability but has failed to prove pneumoconiosis. Thus, in weighing the evidence of the entire record and based on the preponderance of the evidence, I continue to find that Claimant has established total disability but has failed to establish pneumoconiosis pursuant to Sections 718.202(a)(1) and (4) for the above-stated reasons.

ENTITLEMENT

In sum, the newly submitted evidence establishes a material change in condition upon which the prior claim was denied. Claimant has proven total disability. However, he has failed to establish the elements of pneumoconiosis and total disability due to pneumoconiosis. Therefore, Mr. Osborne's claim for benefits under the Act shall be denied.

Attorney's Fees

The award of attorney's fees, under this Act, is permitted only in cases in which Claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for the representation services rendered to him in pursuit of the claim

ORDER

It is ordered that the claim of Bobby J. Osborne for benefits under the Black Lung Benefits Act is hereby DENIED.

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JOSEPH E. KANE
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* C.F.R §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).